INDIANA STATE DEPARTMENT OF HEALTH
BASIC NURSE AIDE TRAINING PROGRAM
PROGRAM NUMBER (ISDH ONLY)_____

PROGRAM SPONSOR:	
ADDRESS, CITY, STATE & ZIP CODE:	
PHONE AND FAX NUMBERS:	PHONE: FAX:
PROGRAM DIRECTOR:	
PROGRAM INSTRUCTOR(S):	
THEORY START DATE AND PROPOSED END DATE:	
CLASSROOM SITE:	
CLINICAL START DATE:	
CLINICAL SITE(S):	
PROPROSED CLINICAL END DATE:	
NUMBER OF STUDENTS:	
TEXT BOOK:	
CLINICAL SUPERVISOR(S):	
TOTAL PROPOSED HOURS:	THEORY: CLINICAL:
ANY DATES THAT CLASS WILL NOT BE IN SESSION (I.E., HOLIDAY OR SCHOOL VACATIONS):	

Approved programs are requested to copy this form for future use. All approved programs must submit program schedule information on this form only. This form, once completed, is to be either faxed or mailed to the Indiana State Department of Health, Division of Long Term Care, 2 N. Meridian St., 4B, Indianapolis, IN 46204. FAX number: 317/233-7322.